‘Minding the Gaps’:
Managing Healthcare through Public-Private Partnerships
in Urban and Rural North Carolina

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I. Executive Summary

Since the turn of the 21st century, escalating healthcare costs and widening gaps in access to care have led the seemingly eternal discussion about an American healthcare crisis to a fever pitch. American employers suffer both from rising costs and complex human resource management challenges due to health-related diminished productivity and turnover. These binary effects are felt most acutely by smaller companies, which have less bargaining power with payers and providers of healthcare as well as a smaller employee base across which to diversify risk. In turn, rural communities, which rely heavily on small businesses to create jobs and economic growth, are struggling to support these businesses even as their local governments and non-profit organizations face similar pressure from healthcare costs. The social and economic implications for communities can be dramatic.

A variety of tactics for managing healthcare costs and access are being explored by private businesses, industry associations, healthcare nonprofits, and the public sector. Many of these strategies attack the symptoms of the current crisis, including health benefit reductions or pure cost-cutting schemes. Partially fueled by the sense among employers and local policy makers that the source of healthcare problems lies at the federal level, and that large-scale structural change will be required in the industry for these issues to be resolved, these strategies are primarily viewed as a “band-aid” to fiscal and resource management challenges. There is evidence, however, of more systemic approaches to community-level healthcare issues.

This paper briefly explores the visible outputs of the United States’ current healthcare system, in particular the recent shifts in cost, quality, and access, and reviews the tactics utilized to manage these aspects of healthcare. To better understand the social and economic implications of this environment for communities, the paper then more fully examines the actual effects of this crisis in North Carolina. It appraises the approaches taken by public and private sector organizations to
managing healthcare and then looks more closely at three examples of cross-sectoral partnerships in order to determine the main differences between urban and rural strategies. Ultimately, implications for future local policy making as well as community action are analyzed and areas for future research are outlined.

II. Methodology

Literature Review  In order to gain a better understanding of the scope and scale of healthcare-related issues in the United States and, on a localized level, in North Carolina, I conducted a broad review of the academic literature published on this field, utilizing resources both at the University of North Carolina at Chapel Hill and at Duke University. I also conducted a literature review of a similar scope on the topic of public-private partnerships, in healthcare as well as in other community and economic development-related fields.

Interviews  To get a sense for the magnitude and direction of the healthcare problem in North Carolina, as well as evidence of any practical application of public-private partnerships related to healthcare, I created an open-ended survey instrument with which to conduct interviews with local health and business leaders across the state. To ensure a diverse sampling of urban and rural markets, I categorized North Carolina’s 100 counties into three tiers based on total (absolute) population, and then randomly selected five counties from each tier in which to conduct my study. I interviewed either the director of the local Chamber of Commerce or Economic Development Commission in each county on the impact of healthcare costs, quality and access issues on local businesses, as well as on the presence of inter- and intra-sectoral partnerships related to healthcare. Where applicable, I followed up with directors of relevant programs within each county. Ultimately, I conducted interviews with thirteen people in nine counties: Chatham, Chowan, Columbus, Forsyth, Halifax, Mecklenburg, Onslow, Watauga, and Yancey. These counties represent a cross-section of North Carolina’s industries, geography (urban versus rural as well as mountainous,
piedmont, and coastal regions), and economic status. For a more detailed summary of the interviews conducted, please see the Appendix.

Analysis I then synthesized the data culled from the literature review as well as the interviews to derive guidelines for potential partners and policy-makers, as well as areas for future research.

III. Description of the Problem: Healthcare in the United States

General Motors’ (GM) recent announcement that it was losing money for the second consecutive quarter primarily because of rising healthcare costs called the country’s attention once again to healthcare’s significant potential economic impact. GM has long been touted as a role-model in the field of corporate healthcare. The company has developed disease-management and preventive care programs to advance the health of its salaried and hourly employees. It is an active member of the Leapfrog Group, a consortium of employers and providers that attempts to inform and positively influence employees’ healthcare choices.1 In addition to these proactive health-management strategies, GM has negotiated extremely generous healthcare coverage benefits with its main union, the United Auto Workers (UAW). Hourly employees at GM pay no monthly premiums and are not responsible for any deductible payments; in all, 119,000 US hourly employees pay only 7% of their total healthcare costs. In contrast, GM’s 38,000 salaried employees, who are responsible for premiums and deductibles, pay an average of 27% of their healthcare costs, and all employees of other companies throughout the US annually foot the bill for 32% of their healthcare costs.2

This commitment to employee health has created a financial liability that GM is being forced to confront, as the short-term financial costs of its healthcare plan have far outpaced any long-term benefits from the company’s comprehensive approach to employee wellness. The plan currently

covers more than one million Americans, making GM the country’s largest private healthcare provider, and costs the company more than $5.5 billion a year. This expenditure accounts for almost $1,600 of the cost of every car they make – far more than is spent by GM’s foreign competitors. Previous efforts to curb costs have included revisions to the company’s healthcare plan for salaried workers, as when GM identified and approved certain “centers of excellence” for major procedures around the country in order to achieve volume-related benefits while ensuring quality and employee productivity, and smaller measures aimed at all employees, such as the encouragement of generic drug usage where appropriate. However, as American car-buyers continue to put pressure on GM to lower prices on its products and industry experts question the viability of the company, GM management is now being forced to consider more drastic measures. GM’s experience presents a high-profile example of the increasingly common health-related cost pressure that many employers are facing.

A. National Healthcare Spending

While GM’s most recent financial crisis may have put a fine point on the healthcare cost issue, various stakeholders in the economic community have been sounding an alarm for some time. Every year the US Department of Health and Human Services issues a report card on the nation’s health. The most recent report, “Health, United States 2004,” reveals that healthcare expenditures in the United States amounted to $1.6 trillion in 2002, a 9.3% increase over the previous year – greater growth than in either of the previous two years, and approaching the 11% annual growth rate of the 1980s. Healthcare spending is expected to top $1.9 trillion this year. At this point, the US spends more per capita on healthcare than any other country (Exhibit 1), including those that

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enjoy universal healthcare coverage.

Healthcare spending represents a greater portion of GDP (over 14%) in the US than in any other industrialized country (see Exhibit 2), and healthcare spending increases represented the largest single component of US GDP growth from 2000 to 2005 (24%), more even than defense spending over the same time period (10%).  

Medicare and Medicaid represent one-fifth of the total US federal budget, and the eligible

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population for these benefits is only increasing as our population ages. Roughly 50% of the increase in total healthcare spending is a result of treatment for chronic, largely preventable conditions, including asthma, obesity and diabetes.\textsuperscript{7} These statistics suggest that healthcare cost increases could continue to rise at this pace for some time.

Identification of the primary reasons underlying these rapidly rising health costs is cause for active debate. Often-heard critics of the US health system point to significant operational inefficiencies, such as mismatched incentives (paying doctors for activities rather than outcomes, or the absence of an individual’s accountability for the cost of his or her healthcare) and artificially suppressed competition. David Cutler, the dean of social sciences at Harvard College and a healthcare economist, offers a relatively simple explanation: technology. Technological innovation in medicine drives the creation of new improved products and treatments that are, as can be expected, expensive. At the same time, technological innovation also increases the efficiency of existing medical treatments and procedures, which drives down their unit cost/price but increases their diffusion throughout the population. Ultimately, in most cases, any pricing pressure is more than offset by increased volume, and the aggregate costs to society continue to increase. Cutler argues that we are getting something for what we are paying, that is, that these cost increases are not simple inflation (paying more for existing levels of care) but that they reflect the rising quality of care in our country.\textsuperscript{8}

Many healthcare professionals and experts agree that each of these issues – along with a number of other strategic, political, and operational concerns – are contributing to rising costs, making the complexity and scale of the problem hard to underestimate. These characteristics have contributed to a sense of permanency around the idea of rising healthcare costs, and as a result many people are attempting to learn how best to operate within the constraints of the current health system, in addition to or in place of actively searching for a long-term comprehensive solution. Attempts to


\textsuperscript{8} Lowenstein. 2005.
operate according to current constraints rather than fundamentally trying to change the system may also be driven by fear that any reduction in cost would be accompanied by a comparable decrease in the quality of care, since, as Cutler points out, these rising healthcare costs are technically purchasing more and better care. However, healthcare spending that grows faster than the GDP means that a diminishing pool of money is available for other expenditures, including investments in education, national security and, most relevant to this paper, the economy.

Upward-spiraling healthcare costs can generate a series of negative macro-economic effects. The primary effect is based on the simple fiscal trade-off just described, in that as more money is spent on healthcare by both the public and private sectors, less money is available to be invested in innovation, capital, and resource development, which can lead to a slowing of growth of the economy. Eventually, if economic growth slows and healthcare costs continue to increase, the annual increase in healthcare spending could surpass the growth in GDP, obliging the government to make some difficult fiscal management decisions. If the government chose to finance our healthcare system using debt, rising interest rates could further exacerbate the negative effects of disinvestment in our economy. On the firm level, micro-economic effects of rising healthcare costs mimic the initial effect described above, in that rapid cost increases force businesses to make financial trade-offs between investments in human resources and investments in other capital. The next sections of this paper look more closely at these business decisions and their direct impact on the firms themselves, as well as their indirect impact on the communities in which these firms operate.

B. Healthcare Costs: Impact on Employers

The financial impact of rising healthcare costs on employers is hard to underestimate. On average, employee benefits represent the third largest expense for most US companies (after cost of goods sold and non-manufacturing payroll), and health insurance is the fastest growing component of the benefits
package. The Department of Health and Human Services annual report indicates that private
employers’ insurance costs rose 10% in 2003 (to $1.41 per employee hour worked). McKinsey & Co.
estimates that by 2008, Fortune 500 companies will be spending on average as much on healthcare as
they earn in profits.\(^9\) Already, American companies are paying on average more than 6% of their total
compensation expense for healthcare,\(^10\) often at the expense of wage increases or other benefits.

Big companies like GM are obviously feeling the burn, but the impact has been felt even more
keenly by many small businesses. Because it is more difficult for insurers to manage the risk
inherent in a smaller group, small businesses often face higher risk premiums for their policies.\(^11\)
Their small purchasing volume minimizes any leverage to negotiate. As a result, a number of smaller
corporations have stopped offering company health plans. A study of healthcare price sensitivity
conducted in 2000 revealed how many more were close to their breaking point. Survey responses
indicated that a 5% insurance premium increase would result in 11% of United States’ small
businesses dropping healthcare coverage for their employees, while almost two-thirds would stop
providing care if premiums rose 20%.\(^12\) For context, insurance premiums have increased on average
more than 10% a year since 2002.\(^13\) Some small business-owners that would like to obtain
healthcare for themselves and their employees have faced challenges beyond their own willingness-
to-pay. In 2000, Actna U.S. Healthcare, owner of Prudential Healthcare, ordered its agents to stop
offering insurance to sole proprietors altogether.\(^14\)

\(^10\) Health, United States 2004.
C. Healthcare Costs: Impact on Society

As companies have chosen or been forced to eliminate their healthcare benefits for employees, the proportion of the population that is covered by private insurance has dropped to levels not seen since the early 1980s. Only 70% of the population under 65 years of age carried private health insurance in 2002 (94% of which came through the workplace), down from 71-73% throughout the late 1990’s and from a high of 77% in 1984. In 2003, 41 million Americans lacked insurance coverage. Observers project that one in three Americans under the age of 65 will lose coverage at some point in the next two years.

Some companies have attempted to stave off the elimination of their health plans by reducing benefits, introducing cost-sharing programs, or passing on increased deductibles and co-payments to their employees. Largely because of this, for the past several years premiums have experienced double-digit growth (Exhibit 3), causing many employed people to opt out of their company health plans either for individual plans or for no plans at all. According to McKinsey, the average annual health insurance premium for a family of four in a PPO reached over $10,000 this year.

![Exhibit 3: Percent Increase in Health Insurance Premiums](image)

Source: Broder, 2002.

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15 Health, United States 2004.
In addition to direct cost-cutting measures, some companies have tried to manage rising healthcare costs by offering wellness programs or investing in other preventive measures. During the 1980s many companies successfully introduced wellness programs as a way to increase productivity by decreasing absenteeism and long-term illnesses. Prudential Insurance Company’s Houston office invested in an exercise program and facility, and saw disability days decline by 20%. For every dollar invested in the program, Prudential estimates a productivity savings of $1.93, and the company claims that participants in the program experienced a drop in average major medical costs from $574 to $312. After investing in its wellness program, the Canadian Life Assurance Company saw similar gains in productivity (their decline in absenteeism estimated at 2.5 days per person, for an aggregate annual savings of $175,000) along with other, less tangible gains. Almost half of their program’s participants reported enjoying work more, being more alert, and getting along better with co-workers, while more than 60% indicated that they felt less tired and more patient while at work. Johnson & Johnson initiated a “Live for Life” program, which included nutrition education, stress management, smoking cessation and fitness components, and saw a 34% decrease in annual hospital costs per participant after two years. However, although these results seemed promising, many companies like GM have been unable to fully offset rising healthcare costs with these productivity gains.

The clearest and most direct effect of being un- or under-insured is declining health status, as demand for healthcare is highly correlated to the level of insurance held by individuals. Although emergency rooms at any hospital participating in the Medicare Program are required to accept patients regardless of ability to pay, and some areas have nonprofit health clinics specifically designed to serve uninsured patients, individuals forced to pay out-of-pocket fees often forgo non-

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20 The 1986 Emergency Medical Treatment and Labor Act (EMTALA) requires that all hospitals provide a medical examination within the capability of the hospital’s Emergency Department to any individual who comes to a hospital requesting treatment for a medical condition.
emergency services, including basic preventive care such as annual examinations or dental cleaning. As a result, illnesses that could be treated relatively inexpensively and easily if diagnosed and treated early ultimately create crises for uninsured individuals, and result in increased healthcare expenses over the long-term. As one physician at the New Richmond Family Practice Center in Ohio put it, “when the uninsured come in, they usually come in sicker. They tend to let things go a lot longer than they should.”21 Access to necessary drug treatments, which represent as a group roughly 17% of total healthcare costs and which have also risen in price substantially, can similarly be hindered by a lack of health coverage. A study sponsored by the American Medical Association and published in 2004 indicated substantial consumer price sensitivity towards pharmaceutical treatments, particularly among diabetic patients.22

The impact of a large un- and under-insured population on the aggregate level of health in our country is significant. Currently, the United States’ health status is below the average of countries included in the Organization for Economic Cooperation and Development (OECD). The US infant mortality rate is 26th out of 30 countries, while the overall life expectancy for Americans at age 65 ranks 16th for females and 18th for males. In terms of process, our healthcare system does benefit from market-based efficiency, as medical services are generally available in a timely fashion. Unlike half of OECD’s countries, the US does not suffer from long waitlists for elective surgery.23 However, the outcomes are clearly not what one might expect given the high relative cost incurred by the system.

Importantly, rising health costs and the associated impacts on health status are not experienced evenly across the nation. There is substantial inequity in health status and cost burdens across

geographical areas and socio-economic and ethnic groups. A 2004 report from the Boston University School of Health demonstrated that poorer states with significant old and/or sick populations are taxed with a significant and disproportional drug cost burden (represented by the ratio of prescription drug spending to income) that is ultimately unsustainable. The authors of the report highlighted the challenges faced by states with these populations for whom reducing drug utilization doesn’t seem to be an option.\(^\text{24}\) Higher costs along with lower access to care result, as mentioned previously, in a population with inferior health. In 2002, health status was reported as fair or poor significantly more often in Southern or non-urban regions (see Exhibit 4), and the percentage of people living below the poverty line that reported fair or poor health (20\%) was more than three times greater than the percentage reporting the same health status in the socioeconomic group earning twice the poverty level (6\%).

<table>
<thead>
<tr>
<th>Exhibit 4: Geographical Disparity in Health Status</th>
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<tbody>
<tr>
<td>% of Persons Reporting Fair or Poor Health</td>
</tr>
<tr>
<td><strong>Geographic region</strong></td>
</tr>
<tr>
<td>Northeast</td>
</tr>
<tr>
<td>Midwest</td>
</tr>
<tr>
<td>South</td>
</tr>
<tr>
<td>West</td>
</tr>
<tr>
<td><strong>Location of residence</strong></td>
</tr>
<tr>
<td>Within MSA</td>
</tr>
<tr>
<td>Outside MSA</td>
</tr>
</tbody>
</table>


Minorities also face health services disparities, in terms both of access and quality of care. A study by the Washington D.C.-based Henry J. Kaiser Family Foundation discovered recently that African Americans across the country who suffer from heart disease, diabetes, cancer, and strokes have a significantly higher death rate than whites suffering from the same diseases. Although some of this

disparity might be explained by differences in levels of insurance, a simultaneous study in the midwest United States of kidney transplants, which are covered by Medicare regardless of socioeconomic status, also indicated that blacks faced substantial barriers to equitable care.\(^\text{25}\)

As a community’s aggregate health status declines, social costs rise. A 2003 Institute of Medicine report investigated the costs to society of an underinsured population. Specifically, the Institute studied the effects of increased morbidity and mortality in terms of decreased labor productivity, increased strain on the capacity of families and nonprofit health providers to care for the uninsured, and inefficient allocation of public funding towards treatment (including criminal justice services for the mentally ill) rather than more cost-effective preventive measures. In the end, the report estimates that between $65 and $130 billion in economic value could be created if all Americans were fully insured, largely thanks to the potential income that uninsured people are instead forced to forego due to poor health.\(^\text{26}\) The report highlighted the real cost of treating the uninsured; in 2001 uninsured individuals received roughly $99 billion worth of medical care. This expense was in large part borne by taxpayers, since any emergency room care received by these individuals was at least partially reimbursed by public funds.

IV. Organizational Responses to Dynamic Social Problems

A. Structural Overview of Public-Private Partnerships

While the social, economic, and political effects of rising healthcare costs and diminished access to care are substantial, their interrelation makes it difficult to precisely evaluate their aggregate impact. The sources of these rising costs, as discussed before, are multiple. Given the dynamic nature of its sources and outcomes, and the multitude of stakeholders impacted by the problem, healthcare is exactly the kind of social problem that partnerships between the public and private


sectors are commonly used to resolve.

The Committee for Economic Development (1982) offers a simple definition of public-private partnerships, which features actors from the public and private sectors participating in strategic coordination for mutual benefit. According to the Committee, this strategic coordination can include both “policy,” or goal articulation, and “operational” dimensions. They identify three general forms for cooperation:

- **Private initiatives for public benefit**, in which private sector organizations act independently towards the public good;
- **Governmental initiatives to facilitate private activity for public benefit**, in which the public sector stimulates, either through action or conscious inaction, private activity for the sake of public benefit; and
- **Joint ventures**, in which the private and public sectors act in concert to benefit both sectors.27

For the sake of this study, I have considered both for-profit businesses and non-profit corporations under the private sector heading.

Other structural categorizations of public-private partnerships abound. Waddock’s (1991) framework for partnerships focuses on the length, scope, and complexity of the joint venture described by the Committee, with “programmatic partnerships” involving relatively few partners and a short-term, narrow focus; “federational partnerships” representing a broader coalition of interests, as in an industry- or geography-based group, tackling an identified need over a longer timeline; and “systemic partnerships” claiming the most diverse set of partners engaging in a formal, comprehensive approach to a complex social, economic, or political issue.28 Keating (1989), with a more specific definitional approach to process, parses the Committee’s joint ventures as they relate to the provision of public works into three separate categories:

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• **Turnkey projects**, which include public ownership and operation with private design and construction;

• **Contracted private operation and maintenance**, with public ownership and private operation; and

• **Voluntary developer/public partnerships**, in which a public project is produced using private funds, or vice versa.\(^{29}\)

Gidron et. al (1992) describe four models in which the government and nonprofits may interact to provide public services, three of which (“third-sector dominant,” “government dominant,” and “collaborative”) resemble the relationships described by the Committee for Economic Development. Gidron’s fourth model, however, describes an additional situation that he calls “dual,” in which government and the private sector work independently of each other towards the same ends. Young (2000) also comments on this ostensibly independent relationship between the public and private sectors, in which private organizations act as a supplement to government.

Najam (2000) provides a descriptive matrix characterizing the relationship dynamics of public-private partnerships based on strategic interests (see Exhibit 5).\(^{30}\)

<table>
<thead>
<tr>
<th>Exhibit 5: Strategic Interests Matrix for Partnerships</th>
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<tbody>
<tr>
<td><strong>Cooperation</strong></td>
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<tr>
<td>Similar ends and means</td>
</tr>
<tr>
<td><strong>Complementarity</strong></td>
</tr>
<tr>
<td>Similar ends, dis-similar means</td>
</tr>
<tr>
<td><strong>Co-optation</strong></td>
</tr>
<tr>
<td>Similar means, dis-similar ends</td>
</tr>
<tr>
<td><strong>Confrontation</strong></td>
</tr>
<tr>
<td>Dis-similar ends and means</td>
</tr>
</tbody>
</table>

Bridgman (2003) focuses on the effects of the partnership on the actual partners, using a bridge as a metaphor for the ability of cross-sectoral partnerships to fundamentally transform each of the participants.

Interestingly, the concept of what exactly constitutes a “public work” has evolved over time, in

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connection with the evolving sense of the government’s role in relation to collective community responsibility. Historically, many services that we now take for granted as public domain were initiated by private firms, including municipal transportation systems, highways, water supplies, and airports. In the past, private investment has been most likely to occur in situations in which government resources are constrained, there is no consensus on how the resources should be allocated or no agreement exists as to whether the service in question is even necessary.\textsuperscript{31} There is evidence that private support for some initiatives with potential, but not proven, public benefits can allow these activities to serve as a “pilot,” eventually establishing the justification and most appropriate model for a full-scale publicly supported program. One example of this is the biomedical field, which received substantial support from private medical associations before being picked up by the federal government.\textsuperscript{32}

In 1977, passage of the Federal Grant and Cooperative Agreement Act officially enabled governmental agencies to enter into partnerships based on joint governance and cost-sharing with other public agencies as well as private institutions. The Act formally defined a set of criteria for a joint decision-making process between the partners\textsuperscript{33} and marked a turning point in the applicability of public-private partnerships towards a broad set of social, economic, and political agendas. Around the same time, a cultural shift was taking place in the nonprofit and public sectors, as institutions that once questioned the motives of private corporations began to welcome positive public actions regardless of the underlying impetus. The Research and Policy Committee of the Committee for Economic Development, a nonprofit think-tank, issued a statement in which it stated: “the incentive for profit is the only practicable way of unleashing the power and dynamism of

\textsuperscript{31} Keating, 1989.
\textsuperscript{33} Brooks 1984.
private enterprise on a scale that will be effective in generating social progress.”

The utilization of public-private partnerships advanced markedly in the early 1980s, as severe federal budget cuts that trickled down to the state and local levels reduced the direct role that the government was able to play in the provision of public services. At the same time, the concept of corporate citizenship started to advance. Many corporations created management roles focused explicitly on public involvement, and devised internal incentives that rewarded activities supporting the public good. This shift was driven by the traditional rationales for public involvement, including positive public relations and true altruism, as well as an emerging understanding of the tightly bound relationship between the health of the external environment and the health of the company. More and more corporations began to invest in the communities in which they did business, and the concept of partnership development evolved into a strategic decision-making process. Companies like Bank of America cultivated business opportunities for themselves by developing whole neighborhoods into viable, sustainable markets, at least partially to strengthen the demand for their products and services. As they became more familiar with these public efforts, they began to see additional opportunities for mutual benefit. Now, public-private partnerships and other cross-sectoral relationships are seen as a viable way to generate revenue with both short- and long-term potential gains.

B. Benefits and Limitations of Partnerships

Public-private partnerships have generated a great deal of success both in terms of outcomes and in terms of process. Successful partnerships can leverage finite resources from multiple sectors in order to accomplish goals of a scale and scope that could not be realized by any single sector. As well, these partnerships can help to build a civic tradition in communities and teach partners how to

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better function as individual institutions.

The shared benefits of any partnership are generated primarily through the effective combination of each partner’s unique capabilities and comparative advantages. Public sector organizations, for example, are able to access restricted sources of public funding, provide assistance maneuvering through federal and local regulations, and help to coordinate various levels of support from other public agencies and institutions. Because these organizations are not subject to fiduciary duties that would require them to consider profitability as a project criterion, they are able to produce public goods and pursue activities that promote equity despite negative short-term financial outcomes.

Private sector organizations, on the other hand, are free from many bureaucratic restrictions imposed on government agencies. They can use longer time horizons when evaluating project risks and potential returns, and are able to provide continuity to projects that is sometimes made difficult by officials subject to an election cycle. Private sector organizations also have their own access to different funding streams, such as the corporate community.\(^{36}\)

The private business sector is frequently touted as highly efficient, since profit motives lead to cost management and the type and scale of production is determined by rational consumer demand. Indeed, the private business sector can offer technical expertise in terms of productive processes and management that does lead to more efficient practices. However, private sector practices are not necessarily always more efficient than those followed by other sectors. The characteristics that make the private sector more efficient, including competition and the incentives for consumer/purchasers to make rational buying decisions, have to be transferred in order to achieve the same efficiency and effectiveness benefits. If certain conditions are not in place, these do not necessarily hold. For example, Weisbrod (1989) argues that when the products or services being purchased are hard to measure, nonprofits can in fact be the most effective and efficient providers.

because they have the least incentive to exploit the uneven information between suppliers and purchasers.\textsuperscript{37}

In support of Weisbrod’s point, nonprofits have increasingly emerged as viable service providers. The ongoing transition to a market-based system indicated by the move toward privatization has opened up opportunities for nonprofits, which traditionally fill gaps created by market or contract failures.\textsuperscript{38} They are not bound by the rule of the majority, as is the government in a democracy like the United States, and so are able to tailor their services to specific consumer segments. They are often able to more efficiently provide services than the bureaucratic and regulation-bound public sector. And, the public tends to view the nonprofit sector with more trust than they do the private sector, primarily because the lack of profit motive implies a sincere dedication to mission.

When public sector organizations are considering whether to partner with private businesses or nonprofits to provide specific services, they should consider the costs and benefits of the particular partnership as well as its political and economic context. Transaction costs, for example, are a significant factor in the decision whether to produce a good or service, to purchase the finished good on the market, or to engage in contracting for production. According to Jacobson (1989), expensive “transaction-specific assets,” such as a specialized plant necessary for a specific production functions or knowledge that takes a long time to acquire, will drive down the number of competitors that any market can support, and increase the likelihood that it is most efficient for any given firm to contract that service out, rather than produce it itself. In addition, situations in which a natural monopoly exists (i.e., when it’s most efficient for a single firm to provide a good or service, as is the case with water lines), public ownership of the service can ensure equity of distribution while competitive bidding for the construction and potentially for the operation of the project can


\textsuperscript{38} Brinkerhoff and Brinkerhoff. 2002.
aid in seeking efficiency. 39 Brooks (1984) offers two possible justifications for public subsidy of private sector organizations. First, government can use public funding to attract expertise and managerial or technical resources to projects to benefit the public good that offer no profit-based motivation for the private sector. And second, government can provide private sector organizations with incentives roughly equal to the social value created by a given initiative. 40

C. Partnership Success Factors and Challenges

Fostering partnerships requires dedicated and talented leadership, to initiate the relationship, to manage the articulation of goals, and to sustain the efforts towards those goals. McCraw (1984) outlines six other critical “pillars to success” for public-private partnerships:

- A sense of crisis. While not sufficient, and possibly not even absolutely necessary, a sense of the immediacy of the need being addressed can motivate partners to make meaningful compromises in the interest of reaching a solution;
- Opportunity for a positive-sum result. All stakeholders must have the opportunity to benefit from the partnership;
- Coherent strategy implemented by first-rate talent. As in all projects, the ability to articulate a clear goal, create a plan to achieve the goal, and then execute on the plan is critical to success;
- High-percentage initial steps. Big early successes can create momentum and overcome potential objections from stakeholders both internal and external to the partnership;
- Identifiable measure of success other than profit. If profit is the only means for evaluation of a potential project, than the public-private partnership will almost always come up short compared to a project completely determined by the market;
- Some means of controlling the agenda and limiting the number of players. Keep the decision-making group manageable and focused. 41

Hutchinson and Foley (1994), on the other hand, describe the challenges faced by almost every

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public-private partnership. Because public-private partnerships often use public dollars, questions can arise regarding the democratic inconsistency of allowing unelected people to wield decision-making power for public resource allocation. The authors suggest that this challenge can be addressed by ensuring that key players in partnerships are both legitimate (“achieved through either having the appropriate interests, qualifications and/or experience”) and accountable to all stakeholders. They have found conflict essentially inevitable in partnerships, due to different cultures, agendas, and personalities. Consciously power-sharing can provide a foundation for the ability of all partners to articulate and resolve conflict. Finally, Hutchinson and Foley invoke the “Rule of Time.” Partnerships with public agencies can be constrained by the budgetary timelines of these agencies, which frequently operate on a yearly basis. However, it takes time to build trust and to organize partnerships, so partners may need to adjust their time horizons or agree to a sequence of projects in order to align different partners’ needs.42

D. Partnerships in Healthcare

Although no single company comes close to the federal government as a payer for healthcare services, the private sector collectively sponsors coverage for more than 165 million people and would be dramatically affected by any shifts in the payer-provider dynamics of the healthcare system, even those ostensibly in the direction of quality and efficiency improvements.43 This considerable stake in the market makes private sector businesses an attractive potential partner. To date, healthcare has been a fertile field for public-private partnerships in each of the structural forms described in the previous section.

Partnerships for Services

Some private sector employers have partnered with community health providers or other local...
public and nonprofit organizations to provide services. Dow Chemical, for instance, has entered into an “educational partnership” with local primary care physicians to help its employees make better health decisions. Dean Foods implemented a partnership program with a local gym in which employees were reimbursed for their membership fees based on actual attendance.\footnote{Peterson, Carolyn. “Employers, providers are partners in health,” \textit{Managed Healthcare}. Cleveland. Vol. 5, Iss. 1. January 1995.}

### Partnerships for Managerial Expertise: Assessments and Goal Setting

Partnerships can be particularly effective during the planning stages of a project, since the diverse perspectives of multiple stakeholders can help to ensure that project goals are realistic, that implementation strategies are effective, and that any potential negative unintended effects are detected and managed ahead of time. For example, nonprofits that are fully engaged in the community can help the public sector to accurately assess health needs on the most localized level.

In the 1990s, the City of Camden, New Jersey, used a nonprofit health research and planning agency to conduct a comprehensive health status assessment of the East Camden neighborhood. Later, this information was made available to a public-private coalition known as the Camden Health Improvement Learning Collaborative that is now working to provide comprehensive healthcare to residents of the inner-city Centreville and East Camden neighborhoods.\footnote{Weech-Maldonado Robert and Sonya B. Merrill. “Building Partnership with the Community: Lessons from the Camden Health Improvement Learning Collaborative,” \textit{Journal of Healthcare Management}. Chicago. Vol. 45, Iss. 3. May/June 2000.}

Private sector organizations can also help projects get off the ground by offering financial and managerial resources. In 1991, a formal public-private partnership known as the Child Development Venture was formed in Lincoln, Nebraska. Employers in the area provided funding and an advisory board to increase staffing, screening, recruiting, licensing and training of childcare providers in the city. To maximize the effectiveness of this contribution, the local government created a staff position in the Health Department known as an employer resource specialist who was
tasked specifically with increasing employer support for childcare. Once the project was fully operational its program components were kept distinct, but the partners continued to work collaboratively when dividing tasks according to capability and capacity. The program has been largely considered a success.46

Partnerships for Technical Expertise: Accountability

Partnerships can also be effective as project phases are completed, offering a combination of objectivity and providing the foundation for ongoing collaborative action. A Health Affairs “Special Report” published in 2004 highlighted several successful partnerships in which grant money from California health philanthropists was used to successfully evaluate the impact of public sector programs.47 Similarly the Hartford Foundation, a $450 million community foundation, helped to develop a program known as the Hartford Health Track in the early 1990s for the state of Connecticut. The program was designed to improve the state’s use of the Medicaid Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), and involved the development of a tracking system for eligible patients as well as community outreach and support for service providers. Within the first 18 months of the pilot program, the number of Hartford children receiving exams as designated by the EPSDT improved by 30%. Participants in the program have expressed the effectiveness of private nonprofits in helping states to design accountability systems.48

Philanthropy has become an increasingly important player in the field of healthcare, and health philanthropists have demonstrated willingness to be a contributing partner in ongoing efforts. In 2002, US health foundations’ assets were valued at $16.4 billion, and health-related grants account for 17% of the nation’s overall foundation giving. Health philanthropists, like most other

philanthropists, are anxious to augment, rather than replace, current public sector services. They have found partnering with the public sector to be challenging, in large part due to differences in the two sectors’ levels of risk-aversion, control of resources, and timeframe. However, offering assistance by ensuring accountability for programs may be one way to add value without getting entangled in conflicts of mission or practice.

Partnerships as Organizational Models

Some public-private “partnerships” have actually interpreted private sector models for human resource management for the use of the public sector. In the 1980s and early 90s increased demand, skyrocketing costs, and dwindling financial resources stimulated government-run health providers such as public hospitals and clinics to attempt substantial cost-cutting measures to try to stay afloat. However, the resulting administrative burden on doctors, as well as the disinvestment in the physical plant, created physician turnover and a decline in private (fully-paying) patients, which in turn created more financial pressure. Jack and Phillips (1993) describe five public-private partnership models that improve upon the traditional employer-employee model found between many public hospitals and their staff: (1) the contract employee model; (2) the medical group model; (3) the faculty practice model; (4) the nonprofit foundation model; and (5) the medical group operator model. They argue that these organizational models allow a better alignment of economic incentives as well as flexibility and better human resources management.  

V. Healthcare Partnerships in Practice in North Carolina

A. State of the Market

Like the rest of the country, North Carolina has been significantly affected by the healthcare crisis. However, the three dimensions of healthcare – cost, quality, and access – are unevenly cited

Representatives in every county surveyed expressed serious concerns about rising healthcare costs and their impact on business as well as individual community members. The statistics they cited were dramatic. In rural Halifax County on North Carolina’s east coast, healthcare costs have risen by more than 30% this year. Over the twelve years that Brenda Blackburn has been working for the Roanoke Valley Chamber of Commerce, her personal healthcare coverage costs have risen from $850 to $3,500 (a 13% compound annual growth rate, compared to less than 3% annual inflation over the same period). In rural Chatham County, premiums have experienced double-digit annual rate increases for the past four years. At this point, a “Family Plan” healthcare coverage in Chatham can cost families more than $1,000 / month (in a county where average monthly rent in 1999 was $278). Urban counties have suffered from the same spikes in health care cost. In Mecklenburg County, health costs have increased by more than inflation for the past 15 years. Most of the people interviewed in both urban and rural counties volunteered that the impact seems to be greatest on small businesses. Dan Meyer, president and CEO of the Boone Area Chamber of Commerce stressed that the feeling of immediacy about healthcare costs is growing: “I’ve been in the Chamber business for 18 years, and until the last two years I haven’t seen small businesses wrestling with these issues – Bush wants to talk about a crisis with social security, but the crisis is here.”

Discussion about the quality of available healthcare does not seem to provoke the same heated responses. In urban counties like Mecklenburg, competition between medical centers has stimulated a broad array of high-quality primary and specialty care services, while large regional hospitals have recently extended marketing campaigns into their dense population centers and created a secondary alternative for specialty care. In rural counties, even in those without hospitals such as Yancey, the quality of primary healthcare services does not raise complaints. In Yancey, private physicians affiliated with the Mission St. Joseph Hospital system in Buncombe County provide care to residents
with health insurance, while the Health Department offers a clinic for the uninsured population.

Access, on the other hand, is a serious area of concern. In North Carolina, as in the rest of the country, the proportion of the population without sufficient health coverage is rapidly increasing. Many of North Carolina’s rural counties have experienced particularly high unemployment over the past decade and, as might be expected, have seen rising un- and under-insurance levels. In Yancey County, which has an unemployment rate over 6%, roughly 20% of the population is uninsured (compared to 14% in the United States\textsuperscript{50}). At the same time that unemployment-based un-insurance has been rising, more and more businesses have either ceased or drastically reduced their offerings of health benefits to employees. Some employers anxious to keep health benefits have shifted a portion of the cost onto employees, through cost-sharing of premiums or increased deductibles and co-payments. The resultant rising costs of company health plans experienced by employees are forcing some to forego the health plans offered by employers. In rural Watauga County in western North Carolina, “people are choosing between paying rent and paying healthcare – and they’re choosing rent.”

On the supply side, many rural counties have insufficient medical services beyond primary care. Yancey County has a shortage of dental care (less than six full-time dentists for a population of 18,000), even for patients with full dental health coverage. A number of counties have found attracting and retaining physicians to be challenging. Columbus County’s nonprofit health clinic offers a loan-forgiveness program for doctors, but has found that many physicians, after paying off loans, leave the clinic to join the private sector. While some of these newly private practice doctors have stayed in Columbus County, a number have not. Jacksonville/Onslow County Chamber president Mona Padrick said that the salaries they are able to offer and a perceived lack of culture in the county can make it difficult to attract doctors. This is a fact that affects rural counties across the

\textsuperscript{50} Gawande, 2005.
US, where almost 20% of the United States’ total population resides and only 9% of the country’s physicians practice.\(^{51}\)

B. Impact of Healthcare on Economic and Community Development

Padrick’s view that “having adequate healthcare is critical – right up there with schools – you just can’t have substandard care” is consistent with the widely-held belief that healthcare is a critical facet of the “quality of life” that businesses covet when evaluating a potential location for their operation. However, because the quality of healthcare available to those who can afford it is both high and relatively even across the state of North Carolina, most of the people interviewed indicated that they did not generally consider healthcare a decisive factor in attracting business to their communities.

North Carolina regulations do require that companies receiving Job Development Investment Grants pay a minimum of 50% of their employees healthcare costs, but since most large companies with multiple locations pay more than 70% of these costs already, this regulation does not seem to present a significant barrier to entry to any particular North Carolina market.\(^{52}\) According to Blackburn, Roanoke Valley Chamber of Commerce’s president, “on the list of 50 things” that businesses think about when considering expansion or relocation of their business, healthcare is at the bottom, since “what you can get here, you can get anywhere throughout the state.”

Despite the broad contention that healthcare was not a critical decision factor in business attraction, however, its importance can vary based on the specific industries being targeted. Watauga County, which touted its “tremendous [healthcare] delivery system” as an asset to traditional economic development, has recently focused on entrepreneurship as an engine for economic growth. The difficulty in obtaining healthcare for small businesses plays a more direct role, then, in the county’s economic development efforts. Watauga representatives also pointed out


that low health status in the county can detract from the overall employability of the population.

Along the same lines, Columbus County, with the third most land in the state and a location only an hour from the beach, has been developing the tourism and retirement segment of its local economy. They contend that although healthcare services in the area might be sufficient, the general health status of residents can be a deterrent, since retirees are looking for a healthy lifestyle.

Retention and sustainable growth of existing companies in all of these counties has been strained by rising healthcare costs. Like the federal government, companies have been forced to choose investment in their own development over investment in healthcare. Jill Atherton of Forsyth County said that because healthcare expenditures directly affect the bottom line, these rising costs can dramatically reduce companies’ discretionary spending. Halifax County’s Brenda Blackburn explicitly connected the inability of companies to dedicate those extra funds to wages or to program development.

As companies facing dramatically increased premiums have reduced healthcare coverage, raised co-pays and deductibles, implemented cost-sharing plans or eliminated healthcare benefits altogether, they have faced increased problems with employee turnover across the state. Small businesses are “at a clear disadvantage to keeping employees,” according to Mecklenburg County’s Lawrence Toliver, while Watauga County has seen many employees in the private sector shift to the public sector precisely because of its better (and perceived to be more stable) benefits.

In addition to challenging the health of businesses, this turnover has had a disproportionate negative effect on certain vulnerable segments of the population. Blackburn commented on the difficult position that companies are put in regarding potentially higher-risk – and certainly higher cost – employees: “we’re not supposed to discriminate based on age, but healthcare costs rise 60% for older employees.” In western rural Yancey County, employers have also described the tension between providing ideal working conditions and the need to stay competitive. According to Gwen
Harris, the executive director of Yancey County Economic Development, companies have expressed a sincere desire to provide healthcare coverage for their employees, but have also expressed their fear that funding expensive benefits puts them at a disadvantage against other countries.

As the level of health coverage starts to decline, both the private and public sectors have begun to feel the strain. In Chatham County, the impact of the uninsured on the operations of the local hospital is significant. Last year, the hospital provided medical services that resulted in gross charges of $22 million. Of that, $2.8 million was on behalf of uninsured patients, only $364,000 (13%) of which was reimbursed. In addition to financial stress, the hospital faces a strain on capacity. Chatham County Hospital’s emergency room sees about 12,000 patients per year, or roughly one per hour. Only 20% of those patients are actually there because of an emergency; the other 80% are using the emergency room as their primary clinic. On a cost-basis, this has a substantial impact – emergency room visits cost $300, while clinic visits only cost $75 – but it also has an impact on the ability of the hospital to be able to effectively care for its true emergency patients. As the “self-pay” proportion of patients increases, the sustainability of the hospital starts to come into question. As Bert Barnette, the hospital’s Chief Financial Officer, put it, the hospital “can’t provide services unless we’re paid,” and “the margin is declining to the point that we can’t reinvest in the business.”

The 50-year-old hospital currently requires a $6-10M capital investment just to maintain its existing facility, and plans for a new facility have been put on hold.

Evidence of this pressure on hospitals can be seen across the state. Chowan County says that the community is “starting to hurt,” since the hospital is legally required to serve everyone regardless of ability to pay, and “someone has to pay the bills.” In Yancey County, a recent County Commissioners meeting broached the topic of the increasing cost burden of Medicaid to the county. This is a particularly onerous issue for small counties like Chowan and Yancey, with limited financial
resources and high levels of unemployment and un- or under-insurance. However, urban hospitals are also being confronted with financial challenges. In March, the North Carolina Baptist Hospital in Forsyth County ended its relationship with Blue Cross Blue Shield (BCBS) after the two sides could not agree to a reasonable increase in fees charged by the hospital for its services. According to several reports, NC Baptist claimed that Blue Cross Blue Shield did not offer as high a reimbursement rate as they were able to obtain from other sources, while BCBS claimed that NC Baptist had obtained a higher reimbursement rate from them than they were offering to any other hospital in the state.\(^{53}\) The 10% of NC Baptist patients that carry Blue Cross Blue Shield insurance will now have to pay significantly more for their treatments if they choose to continue attending NC Baptist. According to Atherton, this could be a “sign of things to come,” as patients who have insurance may see their healthcare options start to be limited.

C. Approaches to the Problem

Lawrence Toliver, the Charlotte Chamber’s vice president for community development, stated simply that businesses are dealing with a “financial problem, so they’re looking for a financial solution.” Businesses across the state have reduced benefits to the point that some packages cover only catastrophic care; increased deductibles and co-pays; implemented premium cost-sharing; or have dropped insurance altogether. The Halifax County Chamber of Commerce, for example, used to pay 100% of healthcare costs but has shifted a portion of these costs to its employees. As a result of this trend, individuals across the county are choosing to opt out of company health plans and into potentially less expensive, individual-coverage programs like Blue Cross Advantage. Onslow County’s Chamber of Commerce has stopped offering health benefits to its employees, in part because the individual plans are so much cheaper for most people. However, these individual plans do not necessarily cover pre-existing conditions. Some businesses in Chowan County are offering

\(^{53}\) “Wake Forest's Baptist hospital says it will cancel Blue Cross contract,” *Triangle Business Journal*. March 4, 2005
allowances to employees in order to purchase their own plans. Other organizations, such as the Charlotte Chamber, are offering their employees a choice between more expensive, comprehensive-coverage plans and less expensive limited-coverage plans.

Dan Meyer, Boone Area Chamber president, claims not to have seen lot of creativity in how companies are approaching the problem beyond one or two businesses transitioning to self-insurance. National companies like Wal-Mart, which is the largest for-profit employer in North Carolina\textsuperscript{34} and can represent a significant source of employment in smaller communities, are circumventing the process altogether by hiring part-time workers for whom benefits are not required or expected. Other companies are reconfiguring their entire benefits package to make room for increasing healthcare costs. One firm employing 80 people in Chowan County recently decided to prioritize its health benefits over any retirement benefits. Evidence suggests that businesses in urban areas are starting to consider relatively sophisticated alternatives such as Health Savings Accounts.

Beyond pure financial management, Bert Barnette of the Chatham County United Chamber of Commerce and Chatham County Hospital believes that preventive care and wellness programs could offer substantial long-term savings for businesses. However, other than in a few healthcare-focused organizations he does not see much evidence of a trend towards wellness. Elsewhere in the state, some larger businesses that have initiated wellness health programs for employees in the past are now investigating ways to reduce the costs of these programs. One Halifax County company with more than 500 employees that had taken progressive steps, including opening an in-house fitness center, now is scaling back its cholesterol screening program.

The governments of counties in the Northeast Partnership (including Chowan and Halifax) have pooled their employees into a single group and been able to achieve purchasing leverage that way. Unfortunately, and this was mentioned by a number of the interviewees, this pooling option does

not exist for small businesses. Several years ago, a legislative loophole that had permitted small businesses to form Health Plan Associations was closed, and since then buying power has been dispersed amongst thousands of small businesses.

The public and nonprofit sectors have recognized the problems caused by rising healthcare costs and limited access. A number of nonprofits across the state have taken on the direct provision of health services, including diagnosis and treatment. For example, a Siler City-based nonprofit pharmacy has used a grant from the health department to offer free and reduced pharmaceuticals to qualified patients. Other nonprofit organizations have taken on supporting roles. In Forsyth County, universities have gotten involved in the training side of healthcare provision. Winston-Salem State University, for instance, has developed a fast-track nursing program to help fill the nursing shortage and to support workforce development efforts in the county. In a similar vein, the Columbus County community college has developed a strong nursing program that has earned the highest certification-examination pass rate in the state.

Local health departments play various roles across North Carolina. In rural Yancey County, the health department directly provides primary care on a sliding fee scale to the un- and under-insured while also actively engaging in strategic community health efforts with a number of partners both in and outside the county, ranging from the development of a comprehensive family health center to making plans for a greenway. The Yancey Economic Development Commission referred me directly to the local health department as a valuable resource, implying that there was an explicit relationship between the health department and business community. In Chowan County, on the other hand, the president of the Chamber of Commerce commented that he knew the county had “a health department; I don’t know what they’re doing.” In Chatham County, the health department operates somewhere in the middle, working with grant funding to operate a number of community services but stopping short of offering direct care. Similarly, in Columbus County the health
department is active but described by the Executive Vice President of the Chamber as, “like many others … overworked.” The department there has attempted to extend their influence into the community via businesses, encouraging local restaurants to carry healthy alternatives and awarding them a “Winner’s Circle” certification if they do.

Rural and urban hospitals also contribute on varying levels to their communities and, in some cases, directly to businesses. Chowan Hospital participates in health screening fairs, and actively engages in tobacco and other educational programs with the county’s employers. In Forsyth, hospitals run outreach programs in which they go to businesses of any size and operate screening and testing programs, for a fee. As well, they operate a center known as “Best Health” at one of the local shopping malls. Originally designed as a screening center, it has evolved to offer community seminars, parenting classes, and other proactive wellness and preventive programs. Halifax County Hospital has a program known as Halifax Works that allows work-related injuries to be treated in a clinic, rather than in the much more expensive emergency room. Halifax Works also provides work-related screenings, such as drug tests, and treatments, such as flu shots, to local businesses at competitive rates. This program is actually a small profit center for the Halifax hospital, which, like many rural county hospitals, must cope with stretched resources due to smaller economies of scale and greater costs associated with serving 75% of their patients on Medicare/Medicaid.

Cross-Sectoral Partnerships

Information about partnerships was not generally volunteered by survey recipients when asked about the actions that companies were taking to address rising healthcare costs, leading me to believe that partner-based strategies are not in the forefront of business leaders’ toolkits for tackling these issues. Watauga’s Chamber of Commerce president offered a viewpoint heard several times; he did not know of any partnerships specifically but thought there may be some “one-off deals.” When prompted more directly about the existence of healthcare-focused partnerships either within or across
sectors, however, descriptions of a number of programs emerged. In general, these partnerships seemed to be project-oriented, focused on a single aspect of healthcare and with a relatively finite scope and timeline. In the next section, I describe three of the most significant cross-sectoral partnerships encountered, which have met with varying degrees of success.

D. Examples of Partnerships in Action

Case 1: “Columbus Drops a Ton”

Columbus County is a large rural county in the southeastern corner of the state with several small towns, the largest of which is Whiteville, the county seat. Columbus has the highest rate of lower extremity amputations due to diabetes in the state, and is one of the top ten counties in the nation for stroke and heart disease. Several key demographic factors contribute to the area’s low health status: the county is poor, and although many of its residents lack education, those who do know why and how to conduct healthier lifestyles often cannot afford to do so. As Janice Young, the executive vice president of the Greater Whiteville Chamber of Commerce, puts it, “macaroni and cheese” is far less expensive than “fresh asparagus.” Although the county has a “fine, fine regional hospital” – Columbus Regional Healthcare System, which claims a cancer treatment center and MRI service, among other specialties – a large percentage of the population has no health coverage, and the Community Health Care Clinic designed to serve the uninsured is challenged to keep physicians despite the loan-forgiveness program described in a previous section of this paper. The Chamber of Commerce, the health department, and other local institutions have been focused on healthy lifestyle issues for some time.

This year, the Columbus Chamber, hospital, local chapter of Healthy Carolinians, Parks and Recreation, and several other smaller public and private organizations teamed up to start a program known as “Fit in 2005,” or, more popularly, “Columbus Drops a Ton.” Focused on incorporating healthy behaviors into everyday life, the group has convinced 2,100 county residents to sign a
contract to adopt five new healthy life choices this year. Working with Columbus community college, primary and secondary schools, and the local newspaper to create awareness of the program, they have gained a groundswell of support for the program. The program started with a simple concept: the creators devised and published a list of 26 healthy behaviors “from A to Z,” including actions such as “wear your Seatbelt” under “S.” They then recruited volunteers to develop a resource manual to support these behaviors, widely distributed the list, and have motivated the community to participate by incorporating competitions between “teams” (made up of private businesses or community groups). The “Dream Team,” the progress of which is being featured in the local newspaper, includes five of the more prominent citizens in Columbus, several of whom have been known to struggle with their health. The program has organized several activities, including “Pacesetter Breakfasts” with healthy fare and information about nutrition, has been highly visible at a number of community events, and is planning an exhibition of local citizens’ hobbies at the upcoming Fire-Ant Festival in order to present alternatives to television to the community.

The partnership is structured relatively informally. The Editor of the local newspaper, the News Reporter, conceived of the idea and shared it with the leader of the Chamber of Commerce, who then approached the other partners and was received with enthusiasm. According to Janice Young, the program has gained momentum of its own as other community members have piled on board. This kind of interaction across sectors is not foreign to the county. The hospital regularly makes deals with local companies revolving around discounted health care for employees, and has a mobile laboratory that offers diagnostic services in the field five to seven times a month. The communication amongst healthcare providers, business community, and residents is fluid and near-constant.

In an editorial written at the kick-off of the program, the organizers claimed to “know they won’t touch everyone in Columbus County and that each participant who pledges won’t meet all
their goals, but [we] at least hope to raise awareness among those who don’t enjoy good health because of the poor choices they make.” Given these goals, the program has so far seemed a success.

**Exhibit 6: Columbus Drops a Ton News Coverage**

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<tr>
<th>SCC smoke-out</th>
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<tr>
<td>The Southeastern Community College nursing department made a start to good ends Thursday during the Great American Smokeout, as members “extinguished” a giant cigarette made by art students. They signed up students and faculty for the letter “Q” in the Columbus Drops a Ton project as they pledged to quit tobacco use.</td>
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*Picture and caption from the Whiteville News Reporter; staff photo by Mark Gilchrist*

**Case 2: “Healthcare Resources for Employers”**

Mecklenburg County, North Carolina’s most populous county and its third wealthiest in terms of median household income, borders South Carolina and almost entirely consists of Charlotte, the state’s largest city. In Mecklenburg, Pfizer, the world’s largest research-based pharmaceutical company, has a formal partnership with the Metrolina Comprehensive Health Center through Pfizer’s national “Sharing the Care” program. Since 1993, Sharing the Care has resulted in Pfizer donating $647 million worth of advanced medicine to low-income, uninsured patients through a network of almost 400 community health centers like Metrolina in both urban and rural areas across the country. Last year, the two partners approached the Charlotte Chamber of Commerce about trying to increase access to healthcare services and drug treatments for Charlotte’s uninsured population. According to Lawrence Toliver, the vice president for community development at the Chamber, the three potential partners spent a considerable amount of time in the early days just “trying to understand each other’s language” as well as to understand exactly the role and resources

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that each stakeholder would be able to present in any team-oriented approach to offering healthcare.

As the rough outline for their program started to take shape, these stakeholders brought representatives of other organizations to the table in order to more fully understand the broad implications of their intended actions. Representatives of the Mecklenburg County Medical Society, MedLink (a program designed to provide assistance to low-income Medicare beneficiaries who do not have Medicaid or other prescription drug coverage, including seniors and the disabled), and Physicians Reach Out (a national program sponsored by the Robert Wood Johnson Foundation that supports innovative community-based models for private practice physicians to increase access to healthcare for the uninsured) joined them. These new partners discouraged the initial group from doing anything that might incentivize companies currently offering health benefits to reduce or cease offering such benefits. Once all the partners agreed to work to avoid these potential negative effects, Toliver made individual presentations to each organization’s board and they formally agreed to collaborate in a strategic alliance. The alliance eventually grew to include United Healthcare (a private insurance company) and Sanofi-Aventis (the world’s third largest pharmaceutical company and the largest in Europe).

The program that Toliver proposed, and that is now underway, is known as “Healthcare Resources for Employers.” The mission of the program is to inform and link small businesses that do not currently offer their employees any health benefits to all appropriate healthcare resources that are available in the community. To do this, Toliver and his group plan to offer quarterly “orientation” sessions for all interested companies. The first session is scheduled for April 15, 2005. The Chamber has identified as its target market 3,000 Chamber members with fewer than 75 employees. To advertise the event, Toliver utilized the Chamber’s in-house printer to produce a four-color postcard focused on the following message:
Exhibit 7: Healthcare Resources for Employers Advertisement

Does the health of your uninsured employees matter to you?
The Charlotte Chamber and its strategic allies announces the creation of

**Healthcare Resources for Employers**

This first of its kind program is specifically and only for companies that do not offer health insurance benefits. On Friday, April 15, 2005, from 7:45 until 9 a.m., Charlotte Chamber members can attend the **Healthcare Resources for Employers Orientation** in the Belk Action Center at 330 South Tryon Street. Companies that are interested in the health of their employees will learn what health services are available to them. Healthcare Resources for Employers grew out of discussions between Pfizer, Metrolina Comprehensive Health Center and the Charlotte Chamber. This leadership has been joined by representatives from the Mecklenburg Medical Society, Physicians Reach Out, MedLink, United Healthcare and Sanofi Aventis Pharmaceuticals.

**Healthcare Resources for Employers Orientations** will take place quarterly.
To register to attend this Friday, April 15th from 7:45 until 9 a.m. orientation, please RSVP by email to XX.

Because the orientation sessions are scheduled to take place quarterly, Toliver sent these postcards to roughly one-fourth (a little more than 900) of the 3,000 companies identified by the Chamber as potential targets, and posted the message on the Charlotte Chamber web site. As of Friday, March 25, he had received only one positive RSVP. Toliver expressed puzzlement at the low response rate, and wondered if concern over liability issues related to employers recommending healthcare providers to employees might be partially to blame.

In general, Charlotte has had great experience with public-private partnerships, particularly in community development and neighborhood revitalization efforts. The City, according to Toliver, is “very proud of going the innovation route” in its commitment to encouraging its own sustainable growth. The city has grown so fast in the past twenty years that it has been continually faced with resource limitations, and partnerships have been critical to mobilizing what available resources there are. In competing for new jobs, according to Toliver, the Chamber’s responsibility is to ensure that expansion prospects get presented with the assets in the community; and “that puts us in the community development business.”

**Case 3: Yancey County Care Facility**

Yancey County, a small, mountainous county in the northwest corner of the state, is in the
bottom tenth percentile of the state in terms of population. The county actually shares many of its
governmental functions – including its health department and medical center; library system; and
community college – with the neighboring counties Avery and Mitchell. The nearest hospital is the
85-bed Spruce Pine Community Hospital, located in Buncombe County 15 miles to the east of
Burnsville, Yancey’s largest town.

Yancey County’s citizens benefit from a variety of partnerships between healthcare providers and
private and public organizations. “Project Access,” funded largely by the Spruce Pine Community
Hospital Foundation and coordinated and staffed by local physicians, offers medical services and
pharmaceuticals at a free or drastically reduced rate to qualified un- and under-insured low-income
residents of Yancey. Primary care physicians and specialists donate their time to the program, seeing
between six and twenty patients per year. The health department runs health centers in the middle
schools with an “incredibly generous” sliding fee scale, and relies on back-up help from local
pediatricians and New Vistas, a local behavioral care facility. The health department also purchases
medicine in bulk and places it at the local CVS (up until a few years ago, the only pharmacy in town),
where health department clients can then fill their prescriptions for free. CVS charges the health
department $1 for each prescription it fills, and Linda Kinnane of the Yancey County health
department is “sure they’re losing money on the deal.” The Mitchell County CVS has a similar deal
with that county’s health department, though they charge slightly more ($3 per prescription) and the
partnership seems to be in flux. The Yancey County CVS manager agreed to this deal six or seven
years ago, and keeps it “under the radar” in order to maintain the program. The Yancey Community
Medical Center has started a partnership with the Yancey, Mitchell, and Madison health departments
in which the Center provides after-hours care to those departments’ patients and bills the health
departments directly. Until the state stopped sanctioning funds for these purposes, the health
department provided worksite health promotions, and it continues to participate in health fairs,
smoking cessation programs, and one-off treatments such as flu shots with businesses.

Several years ago, a Yancey County pediatrician concerned about the number of children without insurance in Yancey County started a nonprofit known as Graham’s Children Health Services of Toe River, with the primary goal of improving the health and quality of life of all Yancey County children. This nonprofit has proved to be an extremely effective partner to the Yancey health department. The two organizations have worked together and incorporated other private and public partners to successfully build a Medicaid Dental Clinic to address the severe shortage of dentists in Yancey County, and have constructed two playgrounds designed to fight childhood obesity.

Perhaps the largest project undertaken by these partners has been the development of a new family healthcare facility in Burnsville. The facility, designed to offer comprehensive care for families, will initially house the Yancey County Medical Center, the Mission Children’s Clinic, the Yancey County Health Department & Home Health, and an EMS facility and telepad. Ultimately the center will include space for the Yancey County Department of Social Services. The site, which is near both the high school and community college, will provide additional meeting space for activities designed to meet community needs, such as parenting classes, AA meetings and blood drives. The project has taken seven years to come to fruition, and has involved multiple partners, including Mission Hospitals, the Yancey County Planning and Economic Development Commission, and the Commission’s nonprofit group, Winter Star. Funding has come from a variety of sources, including grants, state funds, and $2 million from Mission Hospital. The county has both given money to the project and expressed willingness to take out additional low-interest loans if necessary. The county’s commitment to the project is remarkable considering its usual aversion to incurring debt, which allows them to preserve the lowest tax rate in the state.

Partnerships in Yancey County are generally initiated by the health department. Kinnane believes that this is relatively common for the rural counties in the western half of the state, as Buncombe
and Cleveland do the same. When it comes to partnerships initiated by businesses on behalf of their employees, Kinnane commented, “I don’t think people know how to go about it. Nobody knows where to start.”

E. Urban versus Rural Realities

The partnerships described in the previous section vary in a number of significant ways, and highlight some of the realities of urban and rural markets that can dictate the utility of entering into partnerships. First and foremost, smaller counties are constrained by fewer resources that are not necessarily accompanied by a directly proportional decline in the services needed to support their populations. In fact, due to the effects of recent economic transitions, rural county governments have been called upon to provide social services and infrastructure support to a greater extent than the public sectors in urban areas, and struggle to do so on a smaller budget. Beyond the constraints related to the “size of the pie,” however, are constraints related to the pie’s ingredients. Differences in the composition of urban and rural economies, in particular the size of private businesses and the industries in which they operate, can impact the ability of rural areas to develop an effective and efficient community economic development strategy. In addition, evidence remains of a cultural divide between urban and rural markets that may have both positive and negative effects on the ability of communities to create strong partnerships.

North Carolina’s rural counties have economies that are dominated by small businesses. The Halifax County Chamber of Commerce has 600 members, 560 of which employ less than 50 people. Columbus County has only six businesses with more than 500 employees. In Onslow County, 80-85% of Chamber members employ less than 25 employees, and half of those employ less than five. This does not differ radically from rural economies nationally. In 2003, according to the House of Representatives’ Committee on Small Business, 90% of all businesses in rural areas were small
firms.\textsuperscript{56} This has been true for decades; Miller (1990) analyzed the 1980 Small Business Database and discovered that enterprises employing fewer than 100 employees accounted for 41\% of rural area jobs, compared to 35\% in urban areas, and updated research by Winders (2000) confirmed that small businesses were continuing to provide a larger share of jobs in rural markets than in urban areas.\textsuperscript{57} Small businesses are in many ways well-suited to small economies, since their demands on the local labor supply are proportional and their dependence on a single market increases their commitment to the community and encourages sustainable business practices.\textsuperscript{58} Small businesses can also be a real asset to any economy, as Winders (2000) points out: businesses with less than 20 employees have been stronger job growth generators than businesses of any other size. However, maintaining this rate of job growth is difficult. Within the set of small businesses studied by Winders, the subset that employ less than five enjoys a far faster job growth rate, indicating that as small businesses accumulate human and other capital continued growth becomes harder.\textsuperscript{59} Support from the public and nonprofit sectors for small businesses, including infrastructure investments and workforce development, can be a powerful vehicle – and necessary foundation – for sustainable economic progress. However, as survey respondents for this paper have testified, the costs associated with this support can be substantial.

Beyond simply the size of employers, the industry-mix found in rural economies can also present challenges for local communities. Specifically, the quality of jobs available in rural areas can be lower than in urban areas. In Watauga County, for example, the government is the county’s largest employer due to the presence of Appalachian State University, and with those jobs come living wages and comprehensive benefits. However, the rest of the economy “runs on tourism,” with

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\textsuperscript{59} Winders. 2000.
service and retail organizations that typically do not offer high-paying jobs. This, too, parallels the national economy, in which service industries now employ more than 25% of the rural workforce, more than any other sector, and rural workers earn on average 30% less than their urban counterparts. According to Meyer, 40% of the people living in Watauga make less than $9, and none of those jobs offer insurance. In Halifax County, as in many other rural communities, Wal-Mart is one of the few major employers, and many members of its workforce of 400 do not receive health insurance from their employer.

Finally, economic composition is an issue in rural counties because of the ability of one sector to dominate. This is less clearly a positive or negative factor; rather, the critical point is that because of the leverage a single industry can hold, the specific needs and characteristics of that sector must be carefully taken into consideration when developing strategies for rural community development. The specifics of these industries makes generalizing any comprehensive rural lessons learned more difficult. For example, in Onslow County, the military plays a major role in the economy. Like all government jobs, these positions pay well and offer substantial benefits, which have a direct positive effect on the local economy. In addition, the partners and families of military men and women can provide a skilled labor force to help further drive the local economy. However, because military spouses are transient workers, it becomes important to ensure that local residents are dispersed amongst businesses that employ these military spouses in order to provide continuity and stability to counter the high rate of military-relocation related turnover. In Onslow, as in the other rural counties, the small nature of the businesses means that any turnover has a huge impact.

Interestingly, one of the major economic engines in rural counties is often healthcare. In Chowan County, the medical center is a significant factor in economy. According to Richard

Bunch, executive director of the Edenton-Chowan Chamber of Commerce, it is “the major employer, so that most people are connected to the hospital somehow, either through working there or having family work there.” The county has started to actively pursue healthcare-related economic development, recruiting doctors and nurses and supporting technology breakthroughs. Other counties cite the same significant healthcare presence. Watauga County’s third largest single employer is the hospital. Columbus County has one of the top nursing programs in the state at its community college, and has recently expanded the program. According to Janice Young, the executive vice president of the Whiteville Chamber, the school “has been a significant [economic force] – we need the nurses and people need jobs.” Eric Scorsone, assistant professor in the Department of Agricultural Economics at the University of Kentucky recently pointed to the utility of healthcare as an attractive sector: “There are three major roles for healthcare in rural economic development: as a contributor to the local economy; as an industry attracting dollars; and as a factor to recruit businesses, workers and retirees to the community.”

62 The growth of healthcare has without doubt been a positive force in rural economies. Ironically, however, as pointed out by David Cutler, investment in healthcare technology and development can actually contribute to rising healthcare costs. As well, since one of the primary effects of healthcare spending reductions at the local level is, of course, a reduction of healthcare-related income, the significant presence of a local healthcare sector can shape the political dynamics of any cost-containment efforts.

Rural counties thus face the unfortunate combination of populations with an increasing need for healthcare and smaller, predominantly small-business driven economies that are challenged to provide financial and health-related resources. Jill Atherton, the executive director of economic development for the Forsyth County Chamber of Commerce, compared her experience working in an urban county with her time at Davidson Medical Ministries in a rural area and explained that in

urban counties healthcare is “just more accessible.” In Forsyth, the NC Baptist Hospital has drawn on substantial financial resources in order to offer satellite offices and transportation to its branches for the community, essentially nullifying logistics as a challenge to delivering healthcare. In contrast, says Atherton, “[in Davidson] so many people didn’t have access to the private healthcare system that [Medical Ministries was] just swamped.” The intensity of the need and the constraints of the resources and, as mentioned above, the mindset, has powerful implications for the ability of partnerships to address the healthcare issue.

Beyond simply the economic statistics, I encountered an interesting difference in attitudes among the urban and rural markets I studied. The rural areas maintain something of an inward focus, with emphasis on self-sustainability that may be rooted in their agricultural history and traditions. Watauga County’s Dan Meyer referred to his county as a “pioneering place” with a provincial outlook and said, not without some humor, that he was still considered an outsider or “foreigner” because he had only lived there for 16 years. Watauga’s United Way has the slogan “Taking Care of our Own,” and Meyer opined that each of three distinct populations – “natives,” or those born in Watauga County; “foreigners” like himself; and tourists – are expected to care for those within their own group. Often, according to Meyer, families still “take care of their own.” This sentiment was echoed in Yancey County, when the Director of the Chamber of Commerce mentioned that the health department was utilized for primary care largely by the Latino immigrant population in the area, “though a large number of our own” were also reliant upon those health services. In some ways, this inward focus can successfully obviate the need for external support. In other ways, of course, it can challenge the community’s ability to bridge the gap to resources from outside its boundaries – or even those within that are offered by different groups.
VI. Conclusion

Challenges related to healthcare costs, quality, and access are not uniform across urban and rural areas in the state of North Carolina. The approaches to these problems, not unexpectedly, also show considerable variation. In particular, the ways that partnerships are applied to solve the separate but closely related challenges of rising healthcare costs and diminished access, both in terms of mission and in terms of process, may look quite different in urban and rural areas both now and in the future.

Viewed in terms of the structural categories discussed earlier in this paper, the urban and rural partnerships described in the previous section look programmatic, with multiple parties representing a variety of diverse interests and stakeholders coming together to address a specific need or activity. The initiative for these partnerships appears to have come from organizations or individuals that have access to and familiarity with multiple sectors, such as the Chamber of Commerce or the newspaper editor-in-chief. Beyond these important structural similarities, however, the partnerships have several major differences. In particular, the partnerships in the rural counties solely involve local organizations, while the urban partnership extends to include large, multi-national corporations; the development and ongoing operation of the urban partnership was conducted in a formal manner, while the rural programs seem to have evolved more organically; and, finally, the missions of the partnerships vary, in that the rural partnerships were formed in order to create health-related resources for the community, while the urban partnership was established in order to link disadvantaged community members to resources that already existed.

These key differences reflect the constraints and comparative strengths of urban and rural communities. In order to understand how, given these variable characteristics, partnerships can be used most effectively in various environments, we can utilize McCraw’s six pillars of partnership success as a framework for the key issues to be considered. Several of his pillars can be universally
applied in the realm of healthcare partnerships. A “sense of crisis” was clearly conveyed by both urban and rural business leaders interviewed for this study. Importantly, there seems to be an opportunity for a “positive-sum result” as well, since rising health status benefits both the individuals affected and the economic and social health of the collective community. “High-percentage initial steps” will build momentum in both urban and rural communities, and health status improvements provide metrics for success other than profit. Two of McCraw’s pillars stand out, however, for their ability to frame the discussion about how best to create partnerships that are tailored for effectiveness in their specific environments: first, a “coherent strategy implemented by first-rate talent,” and second, “some means of controlling the agenda and number of players.” The way in which these two critical factors for success are implemented may look very different in urban and rural areas, and paying close attention to these components of partnership-development should enable local policy-makers and partners to productively cultivate highly effective programs and ongoing relationships.

In rural areas, direct provision of healthcare services like the ones seen in Yancey County may continue to be the most efficient way to ensure equitable access to healthcare for some time. The familiarity and proximity that many organizations have with each other in less populated counties enable iterative project-oriented partnerships, so less populous areas may also continue to benefit from loosely-formed coalitions like Columbus County’s “Drop a Ton” team, in which grassroots efforts and continuous, fluid contact amongst partners creates an organic process of education, service provision, and institutional learning. In particular, rural counties that experience some of the cultural commitment to “taking care of our own” may find that these “stone-soup” approaches to community care are the most effective way to change behaviors amongst individuals and groups while helping to create an environment of trust that provides a foundation for ongoing collective strategies.
Urban markets, on the other hand, may find that grassroots-focused partnerships have too limited an impact on their broad and diverse populations, and would be difficult to manage if they grew too large, complex, or involved too many players. It seems unlikely that the public sector in urban areas can provide more complete access to care than these areas’ highly developed, comprehensive and competitive healthcare markets. These areas instead have the potential to benefit from leveraging and exploiting resources and relationships that extend far beyond the geographic community limits. These greater resources, however, require much more formal management processes. Effective partnerships in places like Charlotte then, will probably resemble in mission the “Healthcare Resources for Employers” program, in which private and public sector resources are effectively channeled to those who need them. The challenge, of course, is highlighted by Charlotte’s program results. Because formal healthcare partnerships may lack the continuous contact found in rural communities that helps guide effective communication, these partnerships may find it more difficult to solicit the information needed to pinpoint the greatest need in the community. Ensuring that communication channels remain open and are being utilized should help urban partners to create effective partnerships without sacrificing the flexibility and scale benefits that come from having such a highly developed private sector.

Perhaps the largest unexploited potential for partnerships is related to cost-containment and could be used in both the urban and rural markets. Because “healthcare operates solely on a local market basis,” adjustments to how that market functions are most easily made when purchasing power is pooled.63 One powerful partnership-based strategy towards cost-containment might be found in the ability to form small business alliances, or what Waddock referred to as federational partnerships, that then purchase healthcare coverage as a group. The ability of small businesses to achieve better purchasing leverage by pooling both resources and risk could substantially impact

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their capacity to offer healthcare to employees, which in turn could aid their management of human resources by limiting turnover and health-related productivity and ultimately allow these businesses to contribute at a higher level to their local economies. Pooling the risk across companies enables health insurance companies to offer better pricing terms to companies while minimizing their own exposure to risk, so that they could increase their coverage areas and revenue without a corresponding rise in predicted expense. Other benefits that could be shared by employers, employees, and healthcare payers might revolve around information sharing, as the alliance could pool data on effective healthcare procedures and providers, improving long-term care.

However, this approach is not an automatic magic bullet. McCraw’s strategy and partner-engagement pillars are equally relevant for analyzing this partnership opportunity. The first, which calls for a “coherent strategy implemented by first-rate talent,” requires an objective and highly-skilled manager of the alliance and the purchasing process. When Yancey County investigated the possibility for creating a county-wide pool, they estimated that this management position would be a full-time job, and questions were raised about where the funding for this manager would come from. The second pillar, “some means of controlling the agenda and number of players,” is a critical component of establishing the type of long-term partnership that would be necessary to negotiate successfully with healthcare payers. In its exploration of this concept, Yancey County also predicted that it would be difficult to manage an alliance made of small businesses because so many small enterprises, particularly sole proprietors, are mobile and have low barriers to exit. Identification of the specific partners in each community would require the establishment of analysis-based criteria for membership, an honest assessment of potential local partners, and consistent enforcement of the decision-making process. Political and social challenges related to this process are nearly inevitable, and will have to be foreseen and managed effectively.

The alliance structure illustrates the great potential that partnerships hold for large and small
communities for garnering and leveraging resources, exploiting economies of scale, cost- and risk-sharing, and engaging in institutional learning and process improvement. Alliances also serve as a vivid reminder of the administrative and managerial challenges that are inherent to collaborative approaches to social problems. Perhaps most interestingly, alliances may serve as an opportunity for urban and rural economies to learn from each other about how best to structure and maintain effective partnerships. The formal organizational structures utilized in urban areas are necessary to manage the complexity of a private-sector purchasing alliance, while the fluid communication and multiple points of contact that exist in rural communities may provide the key to maximizing the educational benefits of collaboration amongst small businesses. Finding ways to critically observe and then benefit from these “lessons learned” may be one of the keys to effective deployment of partnerships in the future.
References


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“Wake Forest's Baptist hospital says it will cancel Blue Cross contract,” Triangle Business Journal. March 4, 2005


Appendix: Interviews

Summary of Contacts

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<thead>
<tr>
<th>County</th>
<th>Contact</th>
<th>Organization</th>
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<tr>
<td>Chatham</td>
<td>Bert Barnette</td>
<td>Chief Financial Officer, Chatham County Hospital</td>
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<td>Member of the Board, Chatham United Chamber of Commerce</td>
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<td>Richard Bunch</td>
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<td>Brenda Blackburn</td>
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<td>Linda Kinnane</td>
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Appendix: Interviews (cont’d)

Introduction and Survey Questions

Dear Ms. _________,
I am a second-year city and regional planning masters student at the University of North Carolina-Chapel Hill.

For my masters project, I am studying how businesses in North Carolina are managing healthcare for their employees in the face of rising costs and increasing quality concerns. In particular, I am interested in whether/how private sector companies are working with the public and nonprofit sectors to effectively and efficiently provide health-related services and support.

I have chosen a few specific counties in North Carolina to target for this project, and _________ County is one of them. I would be very interested to hear your perspective on the impact of healthcare costs, concerns, and logistics on your county's businesses, as well as your general thoughts regarding local healthcare issues.

Please let me know if you have any time for a quick telephone conversation in the near future. I know that you are very busy, and I really appreciate any time you might spare. If you think that there is another contact on the Chamber of Commerce or elsewhere that might be better suited to answer my questions, please let me know.

Thank you,
Elizabeth Irons

*********
MCRP Candidate, Class of 2005
UNC-Chapel Hill Department of City and Regional Planning
917.613.2873

1) How would you rate the functioning of your county’s current healthcare system (1-7)?
(Major hospitals in the area, % insured, overall health)
2) What role do you feel healthcare plays in your county’s economic development efforts?
3) Are employers in your area concerned about rising healthcare costs?
   a) About healthcare quality?
4) How are businesses managing healthcare costs and quality?
5) Do you see evidence of health-related partnerships or collaborations between the private sector and public or nonprofit sectors?
6) How are the partnerships initiated?
   a) Structured?
   b) What function do they primarily serve?
7) Have partnerships been effective?
   a) What have been the significant challenges and benefits from cross-sector collaboration?
8) Are there any government-sponsored initiatives to deal with healthcare?
   a) Nonprofit?
9) Do you see any opportunities for healthcare programs that aren’t currently in place?
Appendix: Interviews (cont’d)

Economic Profile of Target Counties

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<th>Population</th>
<th>Pop./Sq. Mi.</th>
<th>Geography</th>
<th>Economic Tier</th>
<th>Employment</th>
<th>Unemp. Rate</th>
<th>HH Med. Income</th>
<th>% in Poverty</th>
<th>Pop./Physician</th>
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Target Counties: Major Employers

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University of North Carolina-Chapel Hill, Department of City and Regional Planning
Appendix: Interviews (cont’d)

Target Counties: Geographic Distribution